KTRS Medicare Eligible Health Plan (MEHP)

Sponsored by

Kentucky Teachers' Retirement System

479 Versailles Road, Frankfort, Kentucky 40601-3800

Key Contact Information
Telephone Numbers and Websites

Medicare

- 1-800-MEDICARE (1-800-633-4227)
- For hearing impaired, call 1-877-486-2048
- www.medicare.gov

Aetna

- 1-800-423-3289
- www.aetna.com

Medco

- 1-800-551-8060
- Hearing impaired call 1-800-759-1089
- www.medco.com

Kentucky Teachers' Retirement System (KTRS)

- Call 1-800-618-1687
- In Franklin County, call 848-8500
- www.ktrs.ky.gov

Plan Basics

The plan is a self-insured plan issued to retirees and/or spouses of the Kentucky Teachers' Retirement System (KTRS) who are entitled to Medicare due to attainment of age 65 or Social Security Disability. KTRS utilizes the administrative services of Aetna for medical claims and Medco for prescription drug benefits. The plan benefits are not insured by or funded through Aetna or Medco, but will be paid from KTRS's funds.

TEACHERS' RETIREMENT SYSTEM
OF KENTUCKY

GARY L. HARBIN, CPA
Executive Secretary
(502) 848-8500

C. JOE HUTCHISON, MBA, CPA
Deputy Executive Secretary
(502) 848-8500

SERVING KENTUCKY TEACHERS SINCE 1940

Dear KTRS Retiree:

This KTRS Medicare Eligible Health Plan (MEHP) is a group health plan that is provided to eligible retirees and/or eligible spouses of the Kentucky Teachers' Retirement System (KTRS) who are entitled to Medicare. This plan is self-insured by KTRS, and the plan described in the following pages of this booklet is a benefit plan of KTRS. This booklet outlines your medical benefits and should be used as an informational tool only. If needed, this booklet may also be accessed on our web site at www.ktrs.ky.gov.

The benefits listed in this booklet are **effective January 1, 2006**. Please read it carefully and keep it accessible for future use. **This booklet including the summary of coverage replaces any booklets or summaries of coverage previously issued under this group health plan.**

KTRS has proudly offered a medical plan since 1965. However, these plan provisions and costs are subject to periodic review and members will be notified of any material changes in provisions via KTRS Newsletters and/or special mailings.

Sincerely,

Gary L. Harbin, C.P.A.
Executive Secretary

If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage, starting in 2006. Please see page 22 for more details and pages 53-55 for the KTRS Notice of Creditable Coverage.

Issue Date: 10/2005
Effective Date: 01/01/2006

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SECTION 1:
Summary of MEHP Medical Coverage

KENTUCKY TEACHERS' RETIREMENT SYSTEM
Medicare Eligible Health Plan (MEHP)
Summary of Medical Coverage for Calendar Year 2006

Medicare Service (1)	Medicare Benefits	Medicare Pays
PART A **Inpatient Hospital Services** Semiprivate room and board; miscellaneous hospital services and supplies such as drugs, X-rays, lab tests and operating room	61st through 90th day 91st through 150th day (Lifetime Reserve Days) Beyond 150 days	All but $238 a day All but $476 a day - 0 -
Blood	Blood	All costs except Medicare blood deductible (the cost of the first 3 pints) each calendar year, unless paid for under Part B
PART B **Medical Expenses**	Services of a physician, outpatient services	80% of eligible expenses after $124 deductible
Medical Supplies (other than prescription drugs)	Supplies	80% of eligible expenses after $124 deductible
Blood	Blood	80% of eligible expenses for cost of blood except Medicare blood deductible (the cost of the first 3 pints) each calendar year, unless paid for under Part A
Miscellaneous Immunosuppressive medications	Outpatient medications following a transplant	80% of eligible expenses after $124 deductible for one year beginning with the date of discharge from the inpatient hospital stay during which a Medicare-covered organ transplant was performed
PART A **Part A Deductible**	$952 per benefit period	- 0 - (Please note: Medicare pays all other eligible expenses for inpatient hospital services during the 1st through 60th day.)
Private Room	Private Room	Semiprivate average cost
In-hospital Private-duty Nursing Care	Medically necessary nursing care by a private-duty nurse while in the hospital	- 0 -
Skilled Nursing Facility Care (following a related covered hospital stay of at least three days)	First 20 days 21st through 100th day Beyond 100 days	100% of cost All but $119.00 a day - 0 -
Parts A & B Home Health Care	Part-time or intermittent skilled nursing care and physical or speech therapy	Full cost of eligible expenses, except durable medical equipment is paid at 80%
PART B **Inpatient Prescription Drugs**	Cost of inpatient prescription drugs	Same as inpatient hospital services
Hospice	Medically necessary hospice care	Eligible expenses for hospice care except for 5% of eligible expenses for inpatient respite care during a benefit period; and 5% of eligible expenses for outpatient prescription drugs or $5 toward each prescription, whichever is less
Non-hospital Outpatient Treatment For Mental and Nervous Conditions	Medically necessary services	50% of eligible expenses
Care Received Outside of U.S.A.		- 0 -
Prescription Drugs	Out-of-hospital prescription drugs	- 0 -

(1) **Contacting Medicare**-This outline summarizes what benefits Medicare provides, what the MEHP pays, and what you, the certificate holder, pay with this program. If you have any questions after reviewing this summary, please call 1-800-MEDICARE(1-800-633-4227). This is not a Medicare Supplement contract. If you are eligible for Medicare, review the Medicare Buyers' Guide. KTRS pays secondary when Medicare pays primary. Contact Medicare if you need a copy of the official government handbook for Medicare. For information on your Medicare benefits, contact your Social Security office or the Centers for Medicare and Medicaid Services.

NOTE: **The MEHP benefits are funded by KTRS. The KTRS Board maintains the right to modify, revoke, suspend, terminate or change the MEHP in whole or in part, at any time.**

KENTUCKY TEACHERS' RETIREMENT SYSTEM

Medicare Eligible Health Plan (MEHP)

Summary of Medical Coverage for Calendar Year 2006 *(continued)*

MEHP Pays(2) (3)	Certificateholder (You) Pays
MEHP pays 80% of the remaining Medicare eligible expenses after applicable deductibles and copayments, up to 150 days.	You pay the applicable MEHP deductible and copayments and 20% of the remaining Medicare eligible expenses, and 100% beyond 150 days.
MEHP pays 80% of the remaining Medicare eligible expenses after applicable deductibles and copayments.	You pay the applicable MEHP deductible and copayments and 20% of the remaining Medicare eligible expenses.
MEHP pays 80% of the remaining Medicare eligible expenses after applicable deductibles and copayments.	You pay the applicable MEHP deductible and copayments and 20% of the remaining Medicare eligible expenses.
MEHP pays 80% of the remaining Medicare eligible expenses after applicable deductibles and copayments.	You pay the applicable MEHP deductible and copayments and 20% of the remaining Medicare eligible expenses.
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MEHP pays 80% of the remaining Medicare eligible expenses after applicable deductibles and copayments.	You pay the applicable MEHP deductible and copayments and 20% of the remaining Medicare eligible expenses.

MEHP pays 80% of the remaining Medicare eligible expenses after the MEHP copayment.	You pay the applicable MEHP copayment and 20% of the remaining Medicare eligible expenses.
-0-	Difference between semiprivate and private room costs.
-0-	You pay the applicable MEHP deductible and copayments and 100% of the remaining Medicare eligible expenses.
MEHP pays 80% of the remaining Medicare eligible expenses after applicable deductibles and copayments for the 21st through 100th day.	You pay the applicable MEHP deductible and copayments and 20% of the remaining Medicare eligible expenses, and 100% beyond 100 days.
For durable medical equipment, MEHP pays 80% of the remaining 20% of Medicare eligible expenses after applicable deductibles and copayments.	You pay the applicable MEHP deductible and copayments and the remaining Medicare eligible expenses.
Same as inpatient hospital services.	Same as inpatient hospital services.
MEHP pays 80% of the remaining Medicare eligible expenses after applicable deductibles and copayments.	You pay the applicable MEHP deductible and copayments and 20% of the remaining Medicare eligible expenses.
MEHP pays 80% of the remaining Medicare eligible expenses after applicable deductibles and copayments.	You pay the applicable MEHP deductible and copayments and 20% of the remaining Medicare eligible expenses.
See Footnote (4) below.	See Footnote (4) below.

See separate Summary of MEHP Prescription Drug Coverage.	See separate Summary of MEHP Prescription Drug Coverage.

(2) **Health Expense Coverage**-Health Expense Coverage is expense-incurred coverage only for the treatment of an injury or disease and not coverage for the disease or injury itself. This means that this plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. When a single charge is made for a series of services, each service will bear a pro rata share of the expense. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service. Aetna and the KTRS MEHP assume no responsibility for the outcome of any covered services or supplies. Aetna and the KTRS MEHP make no express or implied warranties concerning the outcome of any covered services or supplies.
(3) **Maximum Benefit**-The maximum benefit of $1,500,000 is available for any covered person in his or her lifetime.
(4) **Foreign Travel**-If you travel outside the U.S.A, this plan is in effect (with limits) during any temporary stay for medical care that is not urgent/emergent. The plan pays 80% of eligible expenses up to a maximum of $5000 per calendar year after applicable deductible. You pay the applicable deductible plus 20% up to $5000 and all costs beyond $5000. True urgent/emergent medical care during any temporary stay will be considered a covered benefit. You must pay the medical expenses, obtain the current exchange rate, an itemized bill, and detailed medical records for all charges to be submitted for reimbursement.

DEDUCTIBLE, COPAYMENTS, COINSURANCE, AND MAXIMUM LIMITS FOR MEDICAL CLAIMS WITH THE MEDICARE ELIGIBLE HEALTH PLAN (MEHP)

Benefit Period .....**Calendar Year**
Medical Deductible **$150.00**

- This annual $150.00 deductible applies to approved medical expenses for covered services, except prescription drugs, unless otherwise indicated.
- **Applies** to maximum annual out of pocket limit for covered expenses.

Inpatient Hospital Copayment Per Admission **$250.00**

- This $250.00 copayment is applicable to **each hospital admission to be applied once during any 60-day period.**
- **Applies** to maximum annual out of pocket limit for covered expenses. Once the maximum annual out of pocket limit for covered expenses is met, this copayment will be **waived** for the remainder of the calendar year.
- Charges subject to this copayment **are not subject** to the Medical Deductible above.

Outpatient Surgery Copayment Per Admission **$125.00**

- This $125.00 copayment is applicable **to each outpatient surgery facility charge to be applied once during any 60-day period.**
- **Does not apply** to maximum annual out of pocket limit for covered expenses. Once the maximum annual out of pocket limit for covered expenses is met, this copayment will **not be waived** for the remainder of the calendar year.
- Charges subject to this copayment **are subject** to the Medical Deductible above.

Covered Person Payment Percentage

- **(CoInsurance)** **20%** after annual medical deductible and applicable copayments.

Covered Person Reduced Payment Percentage For Non-Emergency Care in an Emergency Room

- **(CoInsurance)** **50%** after annual medical deductible and applicable copayments.

Maximum Annual Out of Pocket Limit For Covered Expenses: $1,200 Per covered person, per benefit period, including the medical deductible and the inpatient hospital copayment per admission. The outpatient surgery copayment per admission is excluded. See above for specific applications.

Maximum Lifetime Benefit: $1,500,000 per covered person.

YOUR COVERAGE IS NOT EFFECTIVE WITHOUT PART B OF MEDICARE

Any benefits payable, or which would be payable under Medicare Part B, will be deducted from the medical expenses covered under this plan before benefits of the plan are determined. If you are not enrolled in Part B you will be responsible for the portion that would have been paid by Medicare had you been enrolled in Part B.

GENERAL EXCLUSIONS NOT COVERED BY MEDICARE PART A, MEDICARE PART B, AND THE MEHP

Items and services not covered include, but are not limited to:

- Acupuncture.
- Deductibles, coinsurance, or copayments when you get health care services.
- Dental care and dentures (with only a few exceptions).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Doctor's charges which are in excess of the amount determined to be acceptable by Medicare.
- Eye refractions.
- Health care you get while traveling outside of the United States (except in limited cases).
- Hearing aids and hearing exams for the purpose of fitting a hearing aid.
- Hearing exams (screening) (except in limited cases).
- Intermediate nursing home care costs.
- Long-term care, such as custodial care in a nursing home.
- Orthopedic shoes (with only a few exceptions).
- Prescription drugs—most prescription drugs aren't covered.
- Routine foot care (with only a few exceptions).
- Routine eye care and most eyeglasses (see the 2006 Medicare & You Handbook).
- Routine or yearly physical exams. (If your Part B coverage begins on or after January 1, 2005, Medicare will cover a one-time physical examination within the first six months you have Part B.)
- Screening tests and labs except those listed in the 2006 Medicare & You Handbook.
- Services or supplies that are not medically necessary or that are investigative in nature.
- Shots (vaccinations) except those listed in the 2006 Medicare & You Handbook.

This plan does not cover: any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in this booklet; any portion of a covered expense to the extent paid by Medicare; or expenses incurred after coverage terminates including a person being treated or confined to a hospital when his or her health expense coverage ceases.

*The Centers for Medicare and Medicaid Services or its Medicare publications should be consulted for further details and limitations. These items are subject to change without notice from KTRS or Medicare.

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SECTION 2:
Medical Claims Filing Issues

SECTION 2: MEDICAL CLAIMS FILING ISSUES

HOW TO FILE A MEDICAL CLAIM

A copy of the Medicare Explanation of Benefits (EOB), showing what Medicare has paid, should be sent to Aetna at the address below. If you have enrolled in Part B of Medicare, to avoid filing these claims yourself, you must enroll in the direct claim filing service called Medicare Direct. This program authorizes Medicare to forward your non-hospital claims directly to Aetna for you. Generally, members who have medical coverage in addition to the KTRS MEHP and Medicare are not advised to enroll in this program.

If you have not completed a Medicare Direct Form, you must contact Kentucky Teachers' Retirement System (KTRS) at 1-800-618-1687 to obtain a form. If you are unsure whether you have enrolled in this service, please contact KTRS for verification.

WHEN TO FILE A MEDICAL CLAIM

The Physician or Hospital must first submit the claim to Medicare. The initial claim to Aetna for benefits for each calendar year should be made as soon as your bills for covered expenses exceed your Medicare benefits and your KTRS deductible. Thereafter, bills should be submitted monthly, or less often if expenses are small.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

WHERE TO FILE A CLAIM

Aetna
Group Claims Department
P O Box 981107
El Paso, Texas 79998-1107

Aetna Customer Service
1-800-423-3289

KEEPING RECORDS OF CLAIMS EXPENSES

Keep complete records of the claims expenses. They will be required when a claim is made. The names of physicians and others who furnish services, dates expenses are incurred, and copies of all bills and receipts are very important. Check all bills carefully. Be sure you have received all the services for which you have been billed.

Aetna will furnish you with a statement of expenses submitted and benefits paid with each claim payment. You should keep this statement for income tax and other purposes.

ADDITIONAL CLAIMS FILING INFORMATION

FILING HEALTH CLAIMS UNDER THE PLAN

You may file claims for plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures. Any claims denied by Medicare must be appealed through Medicare's appeal process first.

An "authorized representative" means a person you authorize, in writing, to act on your behalf or as defined in the Health Insurance Portability and Accountability Act (HIPAA). The plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

URGENT CARE CLAIMS

If the plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"A claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

OTHER CLAIMS (PRE-SERVICE AND POST-SERVICE)

If the plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a plan representative responsible for handling benefit matters, but which otherwise fail to follow the plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

ONGOING COURSE OF TREATMENT

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the plan intends to terminate or reduce health claim benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

SECTION 3:
Summary of MEHP Prescription Drug Coverage

SECTION 3: SUMMARY OF MEHP PRESCRIPTION DRUG COVERAGE

DEDUCTIBLE, COPAYMENTS, COINSURANCE FOR PRESCRIPTION DRUG CLAIMS WITH THE MEDICARE ELIGIBLE HEALTH PLAN (MEHP)

You are NOT eligible for the MEHP prescription drug coverage as listed below if you have enrolled in Medicare Part D (see page 22).

Benefit Period .....**Calendar Year**

Prescription Drug Mail Delivery Program (up to a 90-day supply):

Annual Deductible .....**No Deductible**

Member Copayment
Generic Prescription **$10.00**
Preferred Brand Name Formulary Prescription **$20.00**
Non-Preferred Brand Name Formulary Prescription
and Prescription Non-Sedating Antihistamines **$35.00**

Prescription Retail Drug Program (up to a 30-day supply):

Annual Deductible **$150.00**

Member Payment Percentage
Generic Prescription .....**20% after deductible**
Preferred Brand Name Formulary Prescription .....**20% after deductible**
Non-Preferred Brand Name Formulary Prescription
and Prescription Non-Sedating Antihistamines .....**35% after deductible**

****NOTE: If a member chooses a brand drug when a generic is available, the patient is responsible for the applicable copayment plus the difference in cost between the generic and its brand alternative.**

Use of generic drugs and preferred drugs on the formulary list can save you money.

MEDCO CUSTOMER SERVICE
1-800-551-8060

KTRS PRESCRIPTION DRUG PROGRAM SUMMARY DESCRIPTION

The following is a summary of the prescription drug coverage provided to eligible retirees and eligible spouses enrolled in the KTRS Medicare Eligible Health Plan (MEHP). **You are not eligible for the MEHP prescription drug coverage if you have enrolled in Medicare Part D (see page 22).** The two flexible programs, retail and mail delivery, enable you to obtain prescription medications in a safe, convenient and cost effective manner. The KTRS prescription drug program is self-insured and currently administered by Medco. Please visit www.medco.com for pricing comparisons.

MAIL DELIVERY PROGRAM

What is the Mail Delivery Program?

The mail delivery program is a mail order prescription program designed for prescriptions, which are taken on a long-term basis. Up to a 90-day supply can be obtained through the mail delivery program. This program may save you time and money.

How to use the Mail Delivery Program

- Request a new prescription for up to a 90-day supply of medication, plus refills, from your physician. For example, if you take one tablet per day, your physician must write a prescription for 90 tablets. If you take two tablets per day, your physician must write a prescription for 180 tablets, etc.
- Mail your prescription(s) with the special mail delivery service order form obtained by contacting Customer Service at 1-800-551-8060. Or, ask your physician to call 1-888-EASYRX1 (1-888-327-9791) for instructions on how to fax the prescription. If your order is faxed, your physician must include your ID number. Or, you may order online. Visit www.medco.com. Once you are registered and logged in, select the "My Benefits" tab at the top of the page. Then choose the "Request a new prescription" link and follow the online instructions.
- Your prescription is processed and your medications are delivered by mail along with re-order instructions for future refills. Although your prescriptions are filled and shipped within 48 hours of receipt, please allow 14 days from the date you mail your order to receive it.
- If you require non-safety caps, please request them in writing when you mail in your prescription.
- If your doctor prescribes a drug that is available as both a generic drug and a brand name drug, the generic drug will be dispensed unless you or your doctor indicates otherwise.

How to obtain Mail Delivery Refills

There are many ways to obtain prescription refills. Prescriptions can be refilled safely and securely through the Internet at www.medco.com. If you do not have access to the Internet, you may order your refills by calling member services at 1-800-551-8060 and speak with a customer service representative. You may also call 1-800-4REFILL (1-800-473-3455) and use the automated refill system. You will need your ID number, refill slip with the prescription numbers, and your credit card. Also, with your original prescription medication order you will receive a refill notice. Enclose the refill notice with your payment and use the pre-addressed refill order envelopes to obtain refills.

How to save on Mail Delivery Program costs

There is a specific copayment for each drug ordered, which is listed in the front of Section Three. The copayment will vary depending on the type of drug: preferred formulary brand name; non-preferred formulary brand name; non-sedating antihistamine; or generic. The mail delivery program is less expensive than the retail drug program. Also, use of preferred formulary brand name drugs and generic drugs is less expensive for the member than the use of non-preferred formulary brand name drugs.

NOTE: IF YOU CHOOSE TO RECEIVE THE BRAND NAME DRUG WHEN A GENERIC IS AVAILABLE, YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE IN COST BETWEEN THE BRAND NAME DRUG AND THE GENERIC SUBSTITUTE AS WELL AS THE APPLICABLE COPAYMENT.

RETAIL PHARMACY PROGRAM

What is the Retail Pharmacy Program?

The retail pharmacy program is a program designed for initial and short-term prescriptions such as antibiotics. Prescriptions may be filled for up to a 30-day supply of medication at a local, participating pharmacy.

How to use the Retail Pharmacy Program

- Present your prescription drug ID card and physician's prescription(s) to any participating pharmacy.
- The pharmacist will fill your prescription(s), collect the appropriate copayment, and ask you to sign a log to indicate that the medications were received.

PLEASE NOTE: If you choose a pharmacy that is not a participating pharmacy or do not use your prescription ID card, you will pay 100% of the prescription price at the time of purchase. You will need to file a claim form to obtain reimbursement and **you will receive 60% reimbursement.** Find a participating retail pharmacy by visiting www.medco.com or by calling Medco toll-free at 1-800-551-8060.

What is the Retail Pharmacy Program cost?

You will be responsible for paying the first $150.00 of prescription cost for you and the first $150.00 of prescription cost for your spouse (if enrolled) each calendar year. After the $150.00 deductible is met for each, you will pay a copayment equal to 20% of the cost of the drug if you obtain a generic or a brand medication preferred on the formulary. If you receive a prescription that is not preferred on the formulary or is a non-sedating antihistamine, you will pay 35% of the cost of the drug after the deductible is met.

NOTE: IF YOU CHOOSE TO RECEIVE THE BRAND NAME DRUG WHEN A GENERIC IS AVAILABLE, YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE IN COST BETWEEN THE BRAND NAME DRUG AND THE GENERIC SUBSTITUTE AS WELL AS THE APPLICABLE COPAYMENT.

IMPORTANT:

Before leaving your physician's office examine the prescription to make sure the following information is provided and is legible:

- Physician's name, address and telephone number;
- Date medication was prescribed;
- Patient's full first and last name, and mailing address;
- Drug name and dosage, CLEARLY STATED;
- Physician's signature and DEA (formerly BNDD) number;
- Number of times a prescription may be refilled; and
- The generic drug name or indicate whether or not the generic equivalent may be substituted.

PLEASE NOTE: Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions about your medications, please call the toll-free customer service number: 1-800-551-8060.

FORMULARY PROGRAM

What is the Formulary Program?

Your prescription drug benefit program includes a formulary, which is a list of generic and brand name drugs, including a wide selection of medications. It offers you choice while helping keep the cost of your prescription drug benefit program affordable. Every drug on the formulary is Food and Drug Administration (FDA) approved, and reviewed by an independent group of doctors and pharmacists for safety and efficacy. Medco may remind your doctor when a preferred formulary medication is available for a drug that is non-preferred on your formulary. This may result in a change in your prescription. However, your doctor will always make the final decision on your medication.

How may I obtain a formulary guide for my physician?

A formulary guide can be obtained through Medco's website at www.medco.com or by contacting Medco Customer Service. By making this guide available to your physician, he or she will know what preferred formulary and generic drugs can be substituted for non-preferred formulary brand name drugs at a lower cost to you. **However, if your physician chooses to prescribe the non-preferred formulary brand name prescription, you will pay a higher cost. In certain therapeutic drug categories, you will pay the full cost if the physician does not supply a clinical basis for prescribing the non-preferred formulary brand name prescription.**

PRIOR AUTHORIZATION PROGRAMS

What are Prior Authorization Programs?

Prior authorization programs are drug management programs that maintain quality care on certain medications commonly, and unintentionally, abused or misused.

One prior authorization program in which KTRS participates does this by covering certain medications up to present limits established by Medco's independent pharmacy and therapeutics committee. If you attempt to refill a prescription that exceeds the limits, the prescription will be denied for coverage. This denial would only occur when the prescription being filled has reached the recommended limit. This program helps improve quality of patient care and helps protect the patient from inappropriate dosing.

Another prior authorization program in which KTRS participates looks at drugs that may cause potentially serious side effects and dangerous interactions with other drugs. Under this program, certain drugs need pre-approval by Medco for coverage. If you or your covered spouse are prescribed one of these drugs requiring prior authorization, you or your doctor must contact Medco at **1-800-458-8001** for pre-approval.

MEDICARE MODERNIZATION ACT OF 2003 (MEDICARE PART D)

The Medicare Modernization Act of 2003, also known as Medicare Part D, allows Medicare beneficiaries to obtain prescription drug coverage through Medicare. Anyone enrolled in Part A or B of Medicare is eligible for Medicare Part D. **Most KTRS retirees will find it financially beneficial to remain on the KTRS prescription coverage and will not need to enroll in Medicare Part D.** However, low-income Medicare beneficiaries should contact their local Social Security office to determine if it is in their best financial interest to enroll in Medicare Part D and waive the KTRS MEHP prescription drug coverage. If you have both Medicaid and Medicare (dual eligible), you will be automatically enrolled in Medicare Part D and you will not need the KTRS MEHP prescription coverage. Medical coverage will remain intact for anyone enrolled in Medicare Part D. However, you will not be eligible for the KTRS MEHP prescription drug coverage. See pages 53-55 for the KTRS Notice of Creditable Coverage.

What drugs are covered?*

The following are covered benefits when prescribed by a Physician, Dentist, Osteopath, or Podiatrist, unless listed as an exclusion below.

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications
- Insulin
- Insulin Needles and Syringes
- Over-the-Counter Diabetic Supplies (Except for Glucowatch/Glucowatch Sensor)
- Growth Hormones (Included at retail pharmacy only, up to a 30-day supply)

What drugs are excluded?*

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

- Non-Federal Legend Drugs
- ALL contraceptive medications or devices
- Drugs to treat impotency and male or female sexual dysfunction
- Drugs to treat infertility
- Growth Hormones (Excluded at mail delivery only)
- Glucowatch & Glucowatch Sensor
- Mifeprex
- Zyvox (Excluded at mail delivery only)
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine, Propecia) or for cosmetic purposes only (i.e. Renova, Vaniqa, Tri-Luma, Botox Cosmetic).
- Drugs labeled "Caution-limited by Federal Law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication taken as a result of injury or disease caused by an at-fault third party.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescriptions refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

What are the dispensing limits?

In most circumstances, the amount of covered drug to be dispensed per prescription or refill will be in quantities prescribed up to a 30-day supply through a participating retail pharmacy or up to a 90-day supply through the mail delivery service.

***NOTE: While many drugs are covered, all covered and excluded drugs cannot be listed by name in this booklet. This list is accurate at the time of printing. You can contact Medco at 1-800-551-8060 to see if your medication is covered. This list is periodically reviewed and may be subject to change without notice from KTRS or Medco.**

What are the advantages of generic drugs?

Generic drugs save you and your plan money, which helps to maintain your current prescription drug benefit. Generic drugs may have unfamiliar names, but they are safe and effective. Be assured that generic drugs and their brand name counterparts:

- Have the same active ingredients;
- Are manufactured according to the same strict federal regulations.

Generic drugs may differ in color, size, or shape, but the FDA requires that the active ingredients have the same strength, purity, and quality as the brand name alternatives.

Prescriptions filled with generic drugs often have lower copayments. Therefore, you may be able to get the same health benefits at a lower cost. You should always ask your doctor or pharmacist whether a generic version of your medication is available and whether it would be right for you. By using a generic drug, you may be able to receive the same high quality medication but reduce your expenses.

Listed below are some commonly prescribed brand name drugs and their generic equivalents. If you take any of these brand name medications, please ask your doctor to approve the generic equivalent by indicating the generic name on the prescription:

Brand Name	Generic Equivalent
Agrylin	Anagrelide HCL
Coumadin	Warfarin Sodium
Duragesic	Fentanyl
Entex LA	Guaifenesin/Phenylephrine
Entex PSE	Guaifenesin/Psuedoephedrine
Estratest	Methyltestosterone/Estrogen
Estratest H.S.	Methyltestosterone/Estrogen
Folgard RX 2.2	Cyanocobalamin
Foltx	Cyanocobalamin
Glucophage XR	Metformin HCL
Glucotrol XL	Glipizide

Brand Name	Generic Equivalent
Levothroid	Levothyroxine Sodium
Nulev	Hyoscyamine Sulfate
Oxycontin	Oxycodone HCL
Phenergan	Promethazine HCL
Prilosec	Omeprazole
Prinivil	Lisinopril
Remeron	Mirtazapine
Rynatan	Phenylephrine
Synthroid	Levothyroxine Sodium
Ultrase MT 20	Amylase/Lipase/Protease
Viokase	Amylase/Lipase/Protease

These do <u>not</u> represent all the medications that may be dispensed. This is only a sampling of commonly prescribed drugs. This example does not guarantee that these drugs are preferred on the formulary or that they will remain preferred on the formulary.

MEDCO CUSTOMER SERVICE DEPARTMENT
1-800-551-8060--24 HOURS PER DAY--7 DAYS PER WEEK
CUSTOMER SERVICE FOR HEARING IMPAIRED--1-800-759-1089

SECTION 4:
Eligibility for; Enrollment in; and Termination from the MEHP

SECTION 4: ELIGIBILITY FOR; ENROLLMENT IN; AND TERMINATION FROM THE MEHP

WHO IS ELIGIBLE FOR THE MEHP?

Retiree Eligibility
You are in an eligible class if you are a retiree who is entitled to Medicare. Upon retirement, if you are then in an eligible class, your eligibility date is the month following the effective date of your retirement. **NOTE: If you are enrolled in Medicare Part D, you are not eligible for the KTRS MEHP prescription drug program, see page 22.**

Dependant Eligibility
A covered retiree may cover their spouse who is entitled to Medicare. However, coverage in the KTRS plan is through the retired member, which requires the retiree to be enrolled for the spouse to be eligible. Upon the death of a retiree, the retiree's spouse will have 30 days from the date of death to elect coverage or permanently decline coverage. Spouses of deceased retirees will terminate their coverage in the event of remarriage. With the exception of adult handicapped children, children of retirees are not eligible for this plan. **NOTE: If you are enrolled in Medicare Part D, you are not eligible for the KTRS MEHP prescription drug program, see page 22.**

HOW AND WHEN MAY AN ELIGIBLE PERSON ENROLL?

Enrollment Procedures
Upon retirement, if you are in an eligible class, you are entitled to apply for coverage with this plan for yourself and your eligible spouse.

Upon retirement, if you are **not** in an eligible class, you will be enrolled in this plan (if you have not previously waived KTRS coverage) when you become eligible.

Special Enrollment
KTRS retirees and spouses who were previously eligible for coverage, but initially refused coverage and have now lost their other coverage, will be eligible to enroll in the plan during a special enrollment period if certain conditions are met. These special enrollment rules apply to retirees and/or spouses who are eligible but not enrolled under the terms of this plan.

A retiree or spouse is eligible to enroll during a special enrollment period if each of the following conditions are met:

- When enrollment was initially declined, it was stated in writing that coverage under another group health plan or other health insurance was the reason for declining enrollment; and;

- When enrollment was initially declined, the retiree or spouse had COBRA continued coverage under another plan and that COBRA continuation coverage has since been exhausted; or
- If the other coverage that applied to the retiree or spouse when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of the loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes, but is not limited to, a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment.

Special Enrollment Period For Marriage

Retired members who marry may apply to enroll a spouse during a special enrollment period. The effective date would be the first day of the month following the date of marriage. The KTRS enrollment application must be received in our office within 31 days of the date of marriage.

Special Enrollment Rules

To qualify for special enrollment, individuals who meet the above requirements must request and return an enrollment form to KTRS within 31 days of the qualifying event described above. If a retiree seeks to enroll a spouse during the special enrollment period, coverage for the spouse will become effective the first day of the month following the date of the qualifying event, once the completed request for enrollment is received. If you initially refuse coverage for yourself and your spouse, and apply for coverage after the 31 days of eligibility is over, coverage will take effect as provided in the late enrollment section.

Late Enrollment (Open Enrollment)

An eligible retiree or spouse who did not request enrollment for coverage during the first eligible enrollment period, special enrollment period, or who failed to qualify for special enrollment may apply for coverage as a late enrollee during an annual open enrollment period. You may elect coverage only during the annual open enrollment period established by KTRS. You will be notified of the open enrollment period by your KTRS Newsletter or dates can be obtained by contacting KTRS.

Once the completed enrollment form is received, coverage for a late enrollee will become effective on the first day of the month following the end of open enrollment.

HOW AND WHEN WILL COVERAGE TERMINATE?

Retiree coverage will terminate:

- Upon KTRS' receipt of written notice of desire to cancel plan coverage.
- When you are no longer in an eligible class.
- Upon failure to make a required contribution.

Spouse coverage will terminate:

- Upon KTRS' receipt of written notice of desire to cancel plan coverage.
- Upon divorce thus making spouse no longer eligible (spouse may be eligible to continue coverage through COBRA for a limited time period).
- When spouse becomes eligible for this plan under own KTRS retirement.
- Upon failure to make a required contribution.
- Upon remarriage by a spouse of deceased retiree thus making spouse no longer eligible (spouse may be eligible to continue coverage through COBRA for a limited period of time).
- Upon spouse's or retiree's ineligibility.

SECTION 5:
General Information Important to You

COORDINATION OF BENEFITS - OTHER PLANS NOT INCLUDING MEDICARE

Benefits Subject To This Provision: This Coordination of Benefits (COB) provision applies to this plan when a retiree or the retiree's covered dependant has medical coverage under more than one plan. "Plan" and "this plan" are defined herein.

The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Definitions. When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense.
2. If a person is covered by 2 or more plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense, unless the secondary plan's provider's contract prohibits any billing in excess of the provider's agreed upon rates.
4. If a person is covered by one plan that calculates its benefits or services on the basis of reasonable or recognized charges and another plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the plans.
5. The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

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Claim Determination Period means the Calendar Year.

Closed Panel Plan. A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Plan. Any plan providing benefits or services by reason of medical treatment, which benefits or services are provided by one of the following:

A. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
B. Other prepaid coverage under service plan contracts, or under group or individual practice;
C. Uninsured arrangements of group or group-type coverage;
D. Labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans;
E. Medicare or other governmental benefits;
F. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The medical coverage will be coordinated with other medical plans. In turn, the dental coverage will be coordinated with other dental plans.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to another plan covering the person.

When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

Order Of Benefit Determination.

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
B. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

(1) **Non-Dependant or Dependant.** The plan that covers the person other than as a dependant, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependant is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependant; and primary to the plan covering the person as other than a dependant (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) **Active or Inactive Employee.** The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependant of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependant of an actively working spouse will be determined under the above rule labeled D(1).

(3) **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependant) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(4) **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, subscriber longer is primary.

(5) **If the preceding rules do not determine the primary plan,** the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

Effect On Benefits Of This Plan

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

(1) Determine its obligation to pay or provide benefits under its contract;
(2) Determine whether a benefit reserve has been recorded for the covered person; and
(3) Determine whether there are any unpaid allowable expenses during that claims determination period.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. KTRS or Aetna have the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility Of Payment

Any payment made under another plan may include an amount which should have been paid under this plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Aetna will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by KTRS or Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

EFFECT OF MEDICARE PARTS A & B

The following explains medical expense coverage and how Medicare influences this coverage.

- A person is considered Medicare eligible if they are covered under Medicare; or refused Medicare; or dropped Medicare; or did not make proper request from Social Security for Medicare.
- This plan requires that all health expenses covered must first be considered for payment under Medicare. This plan requires you have Part B of Medicare. There will be a charge by Medicare for Part B. However, you are not required to enroll in part A of Medicare if you are not automatically entitled.
- **PART B MEDICARE BENEFITS WILL BE TAKEN INTO ACCOUNT FOR ANY PERSON WHILE MEDICARE ELIGIBLE. THIS WILL BE DONE WHETHER OR NOT THE PATIENT IS ENROLLED IN PART B AND THE PATIENT WILL BE RESPONSIBLE FOR ANY PORTION OF THE CLAIM MEDICARE WOULD HAVE PAID HAD THE PATIENT BEEN ENROLLED IN PART B.**

Charges used to satisfy a person's Part B deductible under Medicare will be applied toward this plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

Any rule for coordinating other plan benefits with those under this plan will be applied after this plan's benefits have been figured under the above rules. Allowable expenses will be reduced by any Medicare benefits available for those expenses.

If it is necessary to administer these COB provisions noted in this section, KTRS or Aetna can release or obtain data and make or recover payments. If the amount of the payments made by the plan is more than it should have paid under these COB provisions, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

HEALTH EXPENSE BENEFITS AFTER TERMINATION

If a person is being treated or confined to a hospital when his or her health expense coverage ceases, benefits will not be extended or available to such person.

TYPE OF COVERAGE

Coverage under this plan is non-occupational or not related to work. Only non-occupational accidental injuries and non-occupational diseases are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

PHYSICAL EXAMINATIONS

The KTRS third party administrator will have the right and opportunity to have a physician of its choice examine any person for whom certification of benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

LEGAL ACTION

No legal action can be brought to recover under any benefit after three years from the deadline for filing claims.

ASSIGNMENT

All coverage may be assigned only with the consent of KTRS or our third party administrator.

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SECTION 6:
Know Your Rights

YOUR RIGHT TO FILE AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION

You are entitled to a review of benefit determinations if you have questions or do not agree with a determination made by Medicare or the MEHP. In most cases you must appeal to Medicare first. Contact or refer to Medicare's publications on the necessary procedures to appeal their benefit determination.

To obtain a review of benefit determinations for the MEHP, you should submit a written request to Aetna at the address listed on your Explanation of Benefits (EOB). Include your group name and group number (i.e. KTRS, 310662). Also include the retiree's Social Security Number, along with the issues and comments you would like to have considered.

HEALTH CLAIMS – STANDARD APPEALS

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to the plan (MEHP). You should submit the appeal to Aetna, and Aetna will forward your appeal and a copy of the relevant information from the initial claim to the plan for response. You will be notified of the plan's decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Aetna's Member Services, who will immediately relay your appeal and relevant information from the initial denial to the plan for response. Aetna's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the plan by telephone, facsimile, or other similar method. The plan will notify you of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with the plan. The second level appeal may be initiated by a telephone call to Aetna's member Services, who will immediately relay your appeal and relevant information from the first level appeal to the plan for response. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the plan within 60 days of receipt of the level one appeal

decision. You should submit the appeal to Aetna, and Aetna will forward your appeal and a copy of the relevant information from the first level appeal to the plan for response. The plan will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

Kentucky Teachers' Retirement System (KTRS)*
Notice of Privacy Practices

This notification is being sent you to satisfy requirements of federal laws relating to HIPAA. No further action is necessary on your part.

We have prepared this notice of our privacy practices for members of our self-insured Medicare Eligible Health Plan (MEHP), and it is being sent to you as required by the Health Insurance Portability and Accountability Act known as HIPAA.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and maintain for future reference.

Personal information is confidential. KTRS protects the privacy of that information in accordance with federal and state privacy laws, as well as our own internal privacy policies. This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information. When we use the term "personal information," we mean financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information" we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care). Please note that others involved in your healthcare such as doctors and pharmacies may send you separate notices describing their privacy practices.

This notice became effective on April 14, 2003.

How KTRS Uses and Discloses Personal Information

We need personal information about you in order to provide you with insurance coverage, which includes health benefits and retail and mail order pharmacy services. In administering the self-funded MEHP along with our third party administrator (TPA) and our pharmaceutical benefits manager (PBM), we may use and disclose personal information in various ways, which are not limited to, but include:

Health Care Operations: We may use and disclose personal information about you during the course of administering our self-funded MEHP – that is, during operational activities such as quality control; performance measurement and outcome assessment; recovery initiatives; cost containment methodologies and assessment; wellness initiatives; data aggregation services; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma, heart failure, gastroesophageal reflux disease or depression. Other operational activities requiring use and disclosure include detection and investigation of fraud; internal or external audits; actuarial studies and valuations; legal services; underwriting and rating; network management; formulary management; and other general administrative activities such as data and information systems management and customer service.

Payment: We may use and disclose personal information in a number of ways to help pay for your covered medical and pharmacy services. Some of these include – conducting utilization and medical necessity reviews; coordinating care; determining eligibility; processing enrollments and terminations; adjudicating or subrogating claims; processing claims; designing and implementing coverage management rules; determining formulary compliance; collecting premiums; calculating cost sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the primary insured). In securing payment from appropriate parties, we may coordinate benefits with Medicare or other payors. In addition, our third party administrator and pharmaceutical benefits manager make claims information available to the subscriber and all covered dependants through their respective websites and via telephonic claims status sites.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may send certain information to doctors for patient safety or other treatment-related decisions.

Additional Reasons for Disclosure: We may use or disclose health information about you in providing you or your physicians or pharmacists with treatment alternatives or reminders, preferred therapies, patient safety alerts, potential drug interactions, formulary alternatives, or other health-related benefits and services, some of which are wellness, prevention, educational health, and disease management programs. We also may disclose such information in support of plan administration to the following -- to Kentucky Teachers' Retirement System as the plan sponsor of the group health plan, as specified in your plan documents; to persons known as business associates who provide services to us and assure us they will protect the information (our TPA, PBM, actuaries and auditors are business associates); to researchers, provided measures are taken to protect your privacy; to state insurance departments, boards of pharmacy, FDA, US Department of Labor, US Department of Health and Human Services and other government agencies that may regulate us; to federal, state and local law enforcement officials for the purpose of law enforcement; in response to a court order or other lawful process regarding legal proceedings; and for the purpose of public welfare to address matters of public interest as required or permitted by law such as threats to public health and safety or national security.

Uses and Disclosures Requiring Your Written Authorization

In situations not specifically permitted under HIPAA and other than those symbolized above, we will ask for your written authorization before using or disclosing personal information about you. If you have given us written authorization, you may revoke it at any time before we act, provided such revocation is in writing.

Member Rights

You have the right to access, inspect, and obtain a copy of your protected health information (PHI) contained in a designated record set that may be used to make decisions about your health care benefits (certain exceptions apply). This PHI may be maintained by our TPA, PBM, or by us. Please write KTRS at the address below to initiate this right. A fee may be charged for the cost of copying, mailing, and other supplies associated with your request. You may make a written request for restriction on certain uses and disclosures of PHI. However, KTRS is not required to agree to a requested restriction. You have the right to receive confidential communications of PHI by alternative means or at alternative locations if the request is reasonable and made in writing. You have the right to submit a written request to have KTRS amend PHI. Amendments will be made by KTRS in cases where such amendments are supported by adequate justification furnished by the member. Upon written request, you have the right to receive an accounting of certain disclosures of PHI, but not for disclosures made before April 14, 2003. The period covered by the accounting can be as long as six years prior to the date on which the accounting is requested. Reasonable fees may be charged if you request such an accounting more than once in a 12-month period. Each member has the right to request a paper copy of this notice from KTRS or make any of the requests above by writing to the address below.

Members may complain to KTRS and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. Complaints to KTRS must be submitted in writing and sent to the Privacy Officer using the address shown below. Federal statutes prohibit any retaliation against a member for filing a complaint regarding violation of health privacy rights.

KTRS Obligations

KTRS is required by law to maintain the privacy of your PHI and to provide members with notice of our legal duties and privacy practices with respect to PHI. KTRS is required to abide by the terms contained in this notice upon its effective date. We reserve the right to change the terms of our privacy notice and to make the new practices effective for all PHI we maintain and will maintain in the future. Members may obtain a copy of any revised notice at www.ktrs.ky.gov or by submitting a written request to the KTRS address shown below.

Written Requests By Mail:	Further Information By Telephone:
Attention: Privacy Officer of KTRS **479 Versailles Road** **Frankfort, KY 40601-3800**	**In Frankfort – 848-8500** **Outside Frankfort – (800) 618-1687**

*** For the purpose of this notice, "KTRS" and the pronouns "we", "us" and "our" refer to the Kentucky Teachers' Retirement System self-funded Medicare Eligible Health Plan. This self-funded health plan has been deemed a covered entity for federal HIPAA privacy purposes.**

DISCLOSURE OF INFORMATION AGREEMENTS APRIL 13, 2005

KTRS, as a retirement system entity and plan sponsor of a group health plan, requests and agrees that the KTRS group health plan, known as the MEHP, will disclose information to the Centers for Medicare and Medicaid Services (CMS), on behalf of KTRS as a plan sponsor. The information given by the MEHP to CMS will be only the information necessary for KTRS, as plan sponsor, to comply with Subpart R of the Medicare Modernization Act and to allow for the treatment, payment, and healthcare operations of our respective drug plans and medical plans. This agreement is to act as a codicil to the following:

Amendment to Summary Plan Description Effective April 14, 2003
For Participants in the Medicare Eligible Health Plan (MEHP)

Disclosure of Protected Health Information to Kentucky Teachers' Retirement System (KTRS), the Plan Sponsor of the MEHP

Effective **April 14, 2003,** the MEHP will become subject to new federal privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rules"). This Amendment describes certain limitations on the disclosure of protected health information by the MEHP to KTRS as a plan sponsor and the measures KTRS as a plan sponsor will take to safeguard this information.

For more information on the privacy practices of the MEHP, please refer to the KTRS Notice of Privacy Practices included in this Summary Plan Description.

What is "protected health information"?

"Protected health information" is information about you, including demographic information collected from you, that can reasonably be used to identify you and that relates to your past, present or future physical or mental condition. Protected health information is also information about the provision of health care or the payment for that care.

How does KTRS as a plan sponsor use and disclose protected health information?

KTRS as a plan sponsor will use or disclose your protected health information for the purpose of carrying out plan administrative functions for the MEHP in a manner consistent with the Privacy Rules. Please refer to the KTRS Notice of Privacy Practices included in this Summary Plan Description for a description of these uses and disclosures.

Protected health information will not be disclosed by KTRS as a plan sponsor for the purpose of employment-related actions or decisions, or in connection with any other benefit plans, unless authorized by the individual. KTRS as plan sponsor of the MEHP does not have an employer relationship with insured individuals of the MEHP.

Certification from KTRS as a Plan Sponsor to the MEHP

The MEHP will only disclose protected health information to KTRS as a plan sponsor given this certification that KTRS as a plan sponsor agrees to comply with the following conditions:

- Not to use or further disclose the information other than as described in the KTRS Notice of Privacy Practices included in this Summary Plan Description, or as required by law.
- Ensure that any agents (including a subcontractor) to whom KTRS as a plan sponsor provides protected health information received from the MEHP agree to the same restrictions and conditions that apply to KTRS as a plan sponsor with respect to such information.
- Not disclose the protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of KTRS as a plan sponsor, unless authorized by the individual. KTRS as plan sponsor of the MEHP does not have an employer relationship with insured individuals of the MEHP.
- Report to the MEHP any use or disclosure of the protected health information that is inconsistent with the uses and disclosures described in the KTRS Notice of Privacy Practices included in this Summary Plan Description of which KTRS as a plan sponsor becomes aware.
- As required by federal privacy regulations,
    1. Make protected health information available to individuals, including for purposes of amendment;
    2. Incorporate any such amendments; and
    3. Make available the information required to provide individuals with an accounting of certain of Plan Sponsor's disclosures of their protected health information.
- Make Plan Sponsor's internal practices, books, and records relating to the use and disclosure of protected health information received from the MEHP available to the Secretary of Health and Human Services for purposes of determining compliance by the MEHP with the Privacy Rules.
- If feasible, return or destroy all protected health information received from the MEHP that KTRS as a plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, but, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.
- Ensure that adequate separation described below in **Separation Between Plan Sponsor and the MEHP** is established.

Separation Between KTRS as a Plan Sponsor and the MEHP

The following classes of employees of plan sponsor may be given access to protected health information received from the MEHP or a third party administrator or pharmaceutical benefits manager of the MEHP: Accountants; Administration; Call Center and Reception; Department Directors; Executive Staff; Imaging Specialists; Insurance Coordinators/Managers/Staff; IT Professionals; Member Services Specialists; Retirement Counselors and Support Staff; and Risk Specialist/Cost Containment Specialist.

The classes of employees identified in the preceding paragraph will have access to protected health information solely to perform the plan administration functions that the plan sponsor performs for the MEHP. Any person who breaches this trust will be disciplined and risks immediate termination. plan sponsor will take necessary actions to mitigate the harmful effects of any known instances of non-compliance.

The foregoing restrictions do not apply in the following circumstances:

- to protected health information disclosed to Plan Sponsor pursuant to a valid authorization from the individual who is the subject of the information;
- to the disclosure of enrollment information to Plan Sponsor; or
- to protected health information that has been summarized in conformity with the Privacy Rules that is used for obtaining premium bids from health plans or modifying, amending, or terminating the MEHP.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator using the phone number on the back of your medical card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORNS' ACT)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's attending provider, after consulting with the mother, from discharging the mother earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

** CONTINUATION COVERAGE RIGHTS UNDER COBRA-GENERAL NOTICE **

Introduction

This notice applies if you are enrolling or have enrolled under the Kentucky Teachers' Retirement System (KTRS) Health Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and eligible dependants that are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your eligible dependants, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the KTRS Insurance Division.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified COBRA beneficiary." A qualified COBRA beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, retirees and their eligible dependants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are a retiree, you will become a qualified COBRA beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

- Your retirement ends; or
- You lose eligibility due to re-employment.

If you are an eligible dependant of a retiree, you will become a qualified COBRA beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- The retiree's retirement ends;
- The retiree loses eligibility due to re-employment;
- The retiree or covered spouse both become enrolled in Medicare;
- The retiree becomes divorced;
- A covered surviving spouse of a retiree loses eligibility;
- The retiree or covered parent-surviving spouse dies; or
- Eligible dependant becomes no longer eligible or no longer dependant.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the KTRS Insurance Division has been notified that a qualifying event has occurred.

You Must Give Notice of the Qualifying Event

For any qualifying event, you must notify the KTRS Insurance Division within 60 days following the date coverage ends with the exception of divorce or loss of eligible dependency which is 60 days following the date of event.

How is COBRA coverage provided?

Upon the KTRS Insurance Division's receipt of a timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Covered retirees may elect COBRA continuation coverage on behalf of their covered eligible spouses, and eligible covered parents may elect COBRA continuation coverage on behalf of their eligible covered dependants. For each qualified COBRA beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage that may last for up to 36 months with the exception of retirement and re-employment related qualifying events, which generally may last up to 18 months.

When COBRA continuation coverage lasts for up to 18 months, there are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or an eligible dependant covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, and you notify the KTRS Insurance Division in a timely fashion, you and your eligible dependants may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If you and your eligible dependants experience another qualifying event while receiving 18 months of COBRA continuation coverage, there may be additional months of COBRA continuation coverage available to your eligible dependants, up to a maximum of 36 months. **In all of these cases, you must make sure that the KTRS Insurance Division is notified of the second qualifying event within 60 days of the second qualifying event.**

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the KTRS Insurance Division or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

In order to protect your rights and the rights of your eligible covered dependants, you should keep the KTRS Insurance Division informed of any changes in address. You should also keep a copy, for your records, of any notices you send to the KTRS Insurance Division.

Plan Contact for Further Information

Kentucky Teachers' Retirement System Health Plan
Insurance Division
479 Versailles Road
Frankfort KY 40601
502-848-8500
800-618-1687

Last printing January 2005

If you experience a COBRA qualifying event, then you will receive the following additional information and notice on electing COBRA:

COBRA CONTINUATION COVERAGE ELECTION NOTICE-Action Required

[*Enter date of notice*]

Dear: [*Identify the qualified COBRA beneficiary(ies), by name or* ***status***]

This notice contains important information about your right to continue your health care coverage in the [*enter name of group health plan, KTRS Medicare Eligible Health Plan*] (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to the KTRS Insurance Division.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [*enter date*] due to [*check appropriate box*]:

☐ The retiree's retirement ends;
☐ The retiree loses eligibility due to re-employment;
☐ The retiree or covered spouse both become enrolled in Medicare;
☐ The retiree becomes divorced;
☐ A covered surviving spouse of a retiree loses eligibility;
☐ The retiree or covered parent-surviving spouse dies; or
☐ Eligible dependant becomes no longer eligible or no longer dependant.

Each person ("qualified COBRA beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [*enter* 18 *or* 36, *as appropriate and check appropriate box or boxes; names may be added*]:

☐ Retiree or former retiree
☐ Eligible Covered Spouse or Covered Surviving Spouse
☐ Eligible Dependant Adult Handicapped child(ren) covered under the Plan on the day before the event that caused the loss of coverage
☐ Adult Handicapped Child who is losing coverage under the Plan because he or she is no longer a dependant or no longer eligible under the Plan

If elected, COBRA continuation coverage will begin on [*enter date*] and can last until [*enter date*].

COBRA continuation coverage will cost $_____ per month for plan year 20_ _. [*enter amount each qualified COBRA beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.*] Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact The KTRS Insurance Division, ATTN COBRA Election, 479 Versailles Road, Frankfort KY 40601 at 502-848-8500 or 1-800-618-1687.

COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to the KTRS Insurance Division. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: The KTRS Insurance Division, ATTN COBRA Election, 479 Versailles Road, Frankfort KY 40601

This Election Form must be completed, signed, and returned by mail. It must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the [*enter name of plan, KTRS Medicare Eligible Health Plan*] (the Plan) as indicated below:

Name Date of Birth Relationship to Retiree SSN (or other identifier)

a. _____

b. _____

c. _____

This form must be completed in its entirety!

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____ _____
Print Address Telephone number

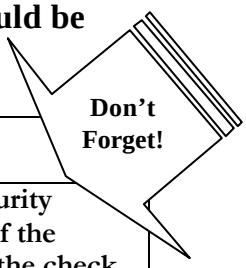
Warning: **Do Not Proceed without following all payment instructions on page three.**

When and how must payment for COBRA continuation coverage be made?
First payment for continuation coverage
If you elect continuation coverage, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is completed and signed by you and post-marked.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the KTRS Insurance Division to confirm the correct amount of your first payment.

Remaining monthly payments for continuation coverage
After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent coverage period. The amount due for each coverage period for each qualified COBRA beneficiary is shown in this notice. The periodic payments must be made on a monthly basis not later than the first day of each following month. If you make a monthly payment on or before the first day of the following month, your coverage under the Plan will continue for that month without any break. It is your responsibility to make timely monthly payments regardless of whether or not the plan sends monthly notices of payments due.

Grace periods for monthly payments
Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.
If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all monthly payments for continuation coverage should be sent to:



Payments:	Check Payable to:	Amount of Check:	Mail to:	Include:
First Payment	_____	$_____ for ___ months	The KTRS Insurance Division ATTN COBRA Election 479 Versailles Road Frankfort KY 40601	Social Security Number of the retiree on the check and include a copy of this election form and notice
Remaining Monthly Payments for Calendar Year 20_ _	_____	$_____	ATTN _____ _____ _____ _____	Social Security Number of the retiree on the check

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give retirees and their eligible dependants the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under this plan. Depending on the type of qualifying event, "qualified COBRA beneficiaries" can include the retiree covered under the group health plan and the covered eligible dependants of the retiree.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified COBRA beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of retirement or loss of eligibility due to re-employment of retiree, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to a retiree's death, divorce or legal separation, becoming entitled to Medicare benefits or a dependant adult handicapped child ceasing to be a dependant under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of retirement or loss of eligibility due to re-employment of retiree, and the retiree became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified COBRA beneficiaries other than the retiree lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified COBRA beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified COBRA beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified COBRA beneficiary,
- a qualified COBRA beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Kentucky Teachers' Retirement System ceases to provide any group health plan for its retirees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage if you have 18 months of COBRA continuation coverage granted?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified COBRA beneficiary is disabled or a second qualifying event occurs. You must notify the KTRS Insurance Division of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified COBRA beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The KTRS Insurance Division will need a copy of the SSA disability determination notice. Each qualified COBRA beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified COBRA beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to eligible covered dependants who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of the retiree, divorce or separation from the retiree, the covered retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependant adult handicapped child's ceasing to be eligible for coverage as a dependant under the Plan. These events can be a second qualifying event only if they would have caused the qualified COBRA beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified COBRA beneficiary has a separate right to elect continuation coverage. For example, the retiree's eligible covered spouse may elect continuation coverage even if the retiree does not. Continuation coverage may be elected for only one, several, or for all eligible covered dependant adult handicapped children who are qualified COBRA beneficiaries. A parent may elect to continue coverage on behalf of any dependant adult handicapped children. The retiree or the retiree's eligible covered spouse can elect continuation coverage on behalf of all of the qualified COBRA beneficiaries.

Important Considerations in Electing COBRA Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you prevent such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Each qualified COBRA beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified COBRA beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including the KTRS, the Commonwealth of KY, and the retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

For more information

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact:

Kentucky Teachers' Retirement System Health Plan
Insurance Division
479 Versailles Road
Frankfort KY 40601

PHONE
502-848-8500
TOLL FREE
800-618-1687

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your rights and the rights of your eligible covered dependants, you should keep the KTRS Insurance Division and the carrier informed of any changes in address. You should also keep a copy, for your records, of any notices you send to the KTRS Insurance Division.

MEDICARE MODERNIZATION ACT
Notice of Credible Coverage
(Medicare Part D Program)

IMPORTANT NOTICE FROM KENTUCKY TEACHERS' RETIREMENT SYSTEM ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Kentucky Teachers' Retirement System and new prescription drug coverage available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. **Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.**

2. **Kentucky Teachers' Retirement System has determined that the prescription drug coverage offered by the KTRS Medicare Eligible Prescription Drug Plan (currently administered by Medco) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you have both Medicaid and Medicare or you qualify for the new Medicare Low-Income Drug Subsidy Program, your expected out-of-pocket costs will be lower than either the standard Medicare prescription drug coverage or the KTRS Medicare Eligible Prescription Drug Plan.**

3. **Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.**

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. Kentucky Teachers' Retirement System has determined that your prescription drug coverage with the KTRS Medicare Eligible Prescription Drug Plan (currently administered by Medco) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you have both Medicaid and Medicare or you qualify for the new Medicare Low-Income Drug Subsidy Program, your expected out-of-pocket costs will be lower than either the standard Medicare prescription drug coverage or the KTRS Medicare Eligible Prescription Drug Plan.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th through December 31st.

If you do decide to enroll in a Medicare prescription drug plan and drop your KTRS Medicare Eligible prescription drug coverage, be aware that you may not be able to get this coverage back until the annual open enrollment period.

If you drop your coverage with the KTRS Medicare Eligible Prescription Drug Plan and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back until the annual open enrollment period. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See pages 16 through 22 of this Summary Plan Description for a summary of the Medicare Eligible Health Plan prescription drug coverage.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive your current health coverage but you will not be eligible to receive prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Kentucky Teachers' Retirement System and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage…
Contact our office for further information at 502-848-8500 or 1-800-618-1687. **NOTE**: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage will be available in October in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare, which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: 09/15/2005
Name of Entity/Sender: Kentucky Teachers' Retirement System
Contact--Position/Office: KTRS Call Center
Address: 477 Versailles Road, Frankfort, KY 40601
Phone Number: 502-564-8500 or 1-800-618-1687

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SECTION 7:
Understanding the MEHP's Rights

RECOVERY OF BENEFITS PAID

To the extent that a medical benefit is paid under this plan for expenses incurred by a covered person due to injury or illness caused by the act of, or the failure to act by a third party, the plan shall be subrogated to (has the right to pursue) all rights of recovery of covered persons against:

- Such third party; or
- A person's insurance carrier in the event of a claim under the uninsured or underinsured motor vehicle coverage provision of an auto insurance policy.

The plan shall have the right to recover from the covered person amounts received by judgment, settlement, or otherwise from:

- Such third party; or
- His or her insurance carrier; or
- Any other person or organization including, but not limited to, the person's uninsured or underinsured auto insurance carrier, or the person's homeowners insurance carrier. The covered person (or his legally authorized representative if the person is legally incapable) shall execute and deliver any documents that are required to do whatever else is necessary to secure such rights.

SUBROGATION AND RIGHT OF RECOVERY PROVISION

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injuries, illness, or condition, including the liability insurer of such party, or any insurance carrier providing medical expense or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage. For purposes of this provision, a Covered Person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the eligible adult handicapped child of any plan member or person entitled to receive any benefits from the plan.

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injuries or illness, to the full extent of benefits provided or to be provided by the plan.

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury, illness, or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a

result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from all Responsible Parties. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury or illness, he/she will serve as a constructive trustee over the fund that constitutes such payment. Failure to hold such fund in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Further, the plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a Covered Person receives from any Responsible Party as a result of the Covered Person's injuries, illness, or condition.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the plan, the Claim Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous, or if questions arise concerning the meaning or intent of any of its terms, the Claim Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

RECOVERY OF OVERPAYMENT

If a benefit payment is made by the KTRS Medicare Eligible Health Plan, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the plan of benefits, this plan has the right:

- To require the return of the overpayment on request; or
- To reduce any future benefit payment made to or on behalf of that person or another person in his or her family by the amount of overpayment.

Such right does not affect any other right of recovery this plan may have with respect to such overpayment.

Key Contact Information
Telephone Numbers and Websites

Medicare

- 1-800-MEDICARE (1-800-633-4227)
- For hearing impaired, call 1-877-486-2048
- www.medicare.gov

Aetna

- 1-800-423-3289
- www.aetna.com

Medco

- 1-800-551-8060
- Hearing impaired call 1-800-759-1089
- www.medco.com

Kentucky Teachers' Retirement System

- Call 1-800-618-1687
- In Franklin County, call 848-8500
- www.ktrs.ky.gov